

CONSENTS, AGREEMENTS, AUTHORIZATIONS, ACKNOWLEDGEMENTS AND IRREVOCABLE ASSIGNMENTS

I. GENERAL CONSENT FOR MEDICAL TREATMENT

Knowing that _____ (Name of Patient) is suffering from a condition requiring diagnosis and medical, dental, or psychological treatment, I hereby voluntarily consent to such diagnostic procedures and hospital care and to such medical or dental treatment, and if appropriate, to such psychological/psychiatric evaluation and treatment, including psychotherapy, and pain medication, as is necessary in the judgment of members of the medical staff of Harris Health or medical staff contracted with Harris Health. I understand that a routine Human Immunodeficiency Virus (HIV) test may be ordered during my visit unless I complete and return the opt-out form. I understand that if a healthcare worker is accidentally exposed to my blood or body fluids in such a fashion that the healthcare worker may be at risk for contracting AIDS, I will be required to have my blood tested pursuant to Texas Law and hospital protocol to determine if I have Human Immunodeficiency Virus (HIV) or other blood borne infections. Test results will be kept confidential to the extent allowed by law and any information concerning my identity in connection with such testing will be destroyed after notification to the healthcare worker who was exposed.

II. CONSENT FOR MEDICAL TREATMENT THROUGH TELEMEDICINE

I may be asked by my healthcare provider to take part in treatment through the use of telecommunication deemed necessary to assist in my medical care. I understand that telemedicine is the use of electronic information and communication technologies by a healthcare provider to deliver services to a patient when the patient is located at a different site than the provider. I voluntarily consent to Harris Health providing health care services to me through the use of telemedicine as may be deemed necessary in the judgment of members of the medical staff of Harris Health, the medical staff contracted with Harris Health, or other Harris Health healthcare providers ("Harris Health Providers"). I understand that Harris Health Providers (i) may practice in a different location than where I present for medical care, (ii) may not have the opportunity to perform an in-person physical examination, and (iii) rely on information provided by me.

My healthcare provider has explained to me how the telemedicine technology will be used to do such a visit.

I understand there are potential risks with this technology:

1. Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment.
2. Security protocols could fail, causing a breach of privacy of personal medical information.
3. Information transmitted may not be sufficient (e.g., poor resolution of images) to allow for appropriate medical decision-making by the Harris Health Provider and consultant(s).
4. A lack of access to complete medical records may result in adverse drug interactions or allergic reaction or other judgment error.

The benefits of a telemedicine visit are:

1. Access to a specialist through this consultation to provide a more efficient medical and health evaluation and management.
2. Improved access to healthcare by enabling me to remain at a remote site while consulting with the healthcare provider.

If Harris Health Providers determine that the telemedicine services do not adequately address my medical needs, they may require an in-person medical evaluation. I understand that if I am referred to another provider, it is my responsibility to ensure that referral instructions are followed timely. In the event the telemedicine session is interrupted due to a technological problem or equipment failure, alternative means of communication may be implemented or an in-person medical evaluation may be necessary. If I experience an urgent matter, such as a bad reaction to any treatment after a telemedicine session, I should alert my treating physician and, in the case of emergencies dial 9-1-1 or go to the nearest hospital emergency department.

I authorize Harris Health to notify my primary care provider, if any, of any telemedicine services provided.

III. USE OF ARTIFICIAL INTELLIGENCE IN CARE

I understand that Harris Health Providers may use artificial intelligence (AI) tools to support clinical decision-making, treatment, and the delivery of healthcare services. These tools assist, but do not replace, the independent medical judgment of your treating providers.

IV. PROFESSIONAL SERVICES

I understand that Harris Health partners and/or contracts with other providers to provide my medical care when I am seen at a Harris Health facility. I understand that the information provided in this document pertains to Harris Health System as well as associated providers.

V. AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize my employer or agent, Harris Health, any physician/doctor practicing within Harris Health, to use or disclose, to any potential or identified payer, my protected health information (medical information and billing records). I acknowledge that my protected health information may contain information about services rendered or products administered to me (or the patient) including references to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, HIV/AIDS, Hepatitis B or C testing, and other sensitive information. I understand that the purpose of the use or disclosure of the personal health information described above is to determine eligibility, process claims, and collect payment from any source of payment for care provided to me including, but not limited to, insurance policies, grants, pharmaceutical patient assistance programs, and drug reimbursement programs.

VI. AUTHORIZATION FOR TEXAS DEPARTMENT OF STATE HEALTH SERVICES

I give permission for authorized employees of Harris Health to enter or view patient/client data in the Texas Department of State Health Services statewide database.

VII. ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of Harris Health's Notice of Privacy Practices.

VIII. FINANCIAL RESPONSIBILITY

I assume full financial responsibility for payment of all charges for service rendered to the above patient. I understand that responsibility is based on the percentage of the balance left after insurance or third-party programs and that this balance **may** be discounted according to the eligibility classification as determined by Harris Health and associated providers. I understand that I may be responsible for two co-insurance amounts: a coinsurance liability for the hospital and a coinsurance liability for the physician/professional services.

IX. WAIVER FOR PERSONAL BELONGINGS

Patients and visitors are responsible for all personal belongings. Harris Health is not responsible for lost, misplaced, stolen, or damaged personal belongings. I have been advised to leave all my personal belongings with friends or relatives and not to bring them to a Harris Health facility. Personal belongings include money, jewelry, medications, documents, items of monetary or sentimental value, clothing, dentures, hearing aids, eyeglasses or contacts, watches, credit cards, wallets or purses, cameras, cell phones, laptops or computers, and medical equipment.

X. ASSIGNMENT OF INSURANCE BENEFITS

In consideration of services rendered, I hereby irrevocably assign and transfer to Harris Health and associated providers for myself and my dependents, all right, title, and interest in the benefits payable for services rendered, provided in any insurance policy(ies) under which I or any of my dependents are insured. Said irrevocable assignment and transfer shall be for granting Harris Health and associated providers an independent right of recovery including but not limited to recovery rights as a third-party beneficiary on said policy(ies) of insurance, but shall not be construed to be an obligation of Harris Health or associated providers to pursue any such right of recovery. I also assign to Harris Health any and all benefits due and/or received on my behalf by Harris Health, under any pharmaceutical assistance or drug reimbursement program.

XI. ASSIGNMENT OF THIRD PARTY CLAIMS, CRIME VICTIMS COMPENSATION

I hereby irrevocably assign to Harris Health and associated providers all right, title, and interest in benefits payable out of any third party action against any other person, entity, insurance company, or out of recovery under the Uninsured Motorist or Medical payment provisions of any automobile insurance policy(ies) or any other insurance policy(ies) under which I may be entitled to recover.

I further authorize Harris Health and associated providers to pursue on my behalf, any claim I may be entitled to pursue before the Crime Victims Compensation Division of the Texas Industrial Accident Board in the event my hospitalization is necessitated by injuries received as the result of a violent crime, but in no event shall this be construed to be an obligation of Harris Health or associated providers. I understand that this agreement in no way restricts my or my dependents' independent right to pursue any such claim before the Crime Victims Compensation Division of the Texas Industrial Accident Board on my behalf. I understand that if Harris Health or associated providers are not paid in full by proceeds of any insurance policies then this assignment does not release my obligation and liability to Harris Health System and associated providers for payment of the services and items provided. I agree to pay Harris Health and associated providers for all charges incurred or alternatively, for all charges in excess of the sums actually paid pursuant to said policies based on my eligibility classification.

XII. MEDICARE PATIENTS (IF APPLICABLE)

I understand that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I request that payment of authorized benefits be made on my behalf. Because this is a provider-based facility, I realize I will incur a co-insurance amount that would not have been charged if this were not a provider-based facility. The outpatient hospital co-insurance amount generally ranges between \$0.00 and \$54.00. This is an estimate and could be higher or lower depending upon the actual services provided.

XIII. DECLARATION

I have read and understand the above initialed consents, agreements, authorizations, acknowledgements and irrevocable assignments. All questions have been fully answered. A photocopy of this document shall be considered as effective and valid as the original.

Signature: _____ Date: _____

Printed Name: _____ Relationship to Patient: _____

Printed Name of Parent(s) (if known): _____

Witness: _____ Date: _____

Patient ID

HARRISHEALTH

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